TASC
Treatment Alternatives for Safe Communities

Testimony to the Illinois Health Care Reform Implementation Council by Peter Palanca, TASC Executive Vice President November 16, 2010

Members of the Council, thank you very much for the opportunity to testify today. My name is Peter Palanca, and I am the Executive Vice President of TASC. TASC is a statewide nonprofit agency with statutory authority to perform substance use disorder assessments, case management, monitoring, and referral to treatment and other recovery support services for the Illinois criminal justice system. We work with criminal courts and probation departments throughout the state, and we also provide services for a number of prison- and jail-based reentry programs as well as jail and prison diversion programs. Since 1976, TASC has been engaged in care management, designing and administering numerous programs that connect courts, jails, and prisons with supervised substance use and mental health treatment and recovery support services in the community. This approach of combining justice mandates with substance use and mental health goals is used in jurisdictions throughout the country and consistently improves client outcomes and saves public dollars.

I am here today to discuss the potential of health care reforms to build on Illinois' significant investment in behavioral health interventions to reduce drug-related crime. These reforms can be leveraged to improve health, increase public safety, and **create current year budget savings** for the state and county criminal justice systems. Leveraging the reforms that will significantly expand the Medicaid program to achieve these outcomes is within reach – *if* the right steps are taken now and as planning and implementation efforts continue. From our perspective, the right steps include:

- Building partnerships between Medicaid, health care and the criminal justice system;
- Expediting Medicaid enrollment for people in the criminal justice system; and
- Leveraging reforms to treat people in the community rather than manage them in the criminal justice system, using best practices to maximize public safety and public health.

The criminal justice system represents one of the largest catchment areas for people with substance use and mental health conditions, infectious diseases, and other chronic health problems. Each year across Illinois, over 36,000 people are admitted and released from state prisons,[1] and over 360,000 people pass through local jails.[2] Compared to the general population, justice-involved populations have disproportionately high rates of chronic medical conditions,[3] substance use disorders, serious mental illness, and co-occurring substance use and mental health disorders.[4] In 2008, between 49 and 87 percent of arrestees tested positive for illicit drugs in one survey.[5] Two-thirds of jail detainees report

using drugs regularly.[6] Between 45 and 53 percent of prison inmates meet the clinical criteria for substance abuse or dependence, and more than half reported using drugs in the month before their arrest.[7] These conditions, which contribute to recurring criminal behavior, usually are untreated or inadequately treated.

Like other chronic conditions, substance use and mental health disorders require ongoing, long-term treatment and management. Most people with these disorders need at least three months in treatment to stop or significantly curtail their use,[8] and current research shows that attaining durable recovery typically involves multiple episodes of care over several years.[9] The acute care treatment currently offered in jail and justice settings is insufficient to address chronic conditions. For those who receive it, treatment in jail can begin the process of recovery, but continued services in the community are necessary for recovery to be sustained.[10]

The criminal justice population historically has very low rates of health insurance—90 percent among jail detainees in one study[11]—and no access, or interrupted access, to health care services and treatments. The continuity of care necessary to manage chronic conditions is unlikely to occur without oversight and coordination and access to adequate health care.

It will be an enormous change in landscape when Medicaid eligibility expands in 2014 to include unmarried adults, a demographic that includes most of the people passing through local jails and State prisons. This change in landscape will occur for both for the individuals involved in the justice system and for the justice and treatment systems. Should continuous, integrated health care services—particularly treatments for substance use and psychiatric disorders contributing to criminal behavior, arrests, and incarcerations—become widely available for justice-involved populations, a reduction in criminal behavior and repeated incarcerations associated with these chronic health conditions can be expected.

Consider a theoretical, medium-sized county jail with a 500-bed capacity. (Kane and Lake County Jails house have capacity to house approximately 600 inmates each; Madison and Peoria County Jails house approximately 400 inmates each.) With the rapid turn of inmates in the jail, this 500-bed jail will house at least 13,000 people each year,[12] of whom potentially 8,580 (two thirds) have substance use conditions calling for some level of clinical intervention[13] and 1,885 (14.5 percent) have psychiatric disorders that require treatment.[14] Detainees who pass a criminal justice risk assessment—those charged with nonviolent offenses—could participate in conditional release with community treatment. Should this mid-size jail direct more arrestees to supervised release with the condition of community treatment, the county's annual costs for incarceration would be reduced. By decreasing the number of detainees by only 10 percent, this mid-size county could save more than $1 million in incarceration costs in one year.[15]

In Illinois, reducing IDOC admissions through expanded diversion programs will result in substantial savings to the state. A 5 percent reduction in annual admissions to the

Department would save an estimated $45 million in one year.[16] Reductions in recidivism can also be obtained through broad referrals to treatment for parolees and probationers.

Proven models for these initiatives exist at all points of criminal justice supervision. Prosecutorial diversion programs, such as the Cook County State's Attorney's Drug Abuse Program, and prison diversion programs like TASC, have long demonstrated their value in reducing incarceration. Table 1 outlines strategies that have been proven to maintain public safety while reducing incarceration and increasing recovery.

Table 1. Criminal Justice Strategies to Reduce Public Expenditures and Maintain Public Safety

Strategy	Target Group	Impact
Diversion at Arrest. Law enforcement directs to hospital emergency room or community treatment	People with psychiatric disorders causing disturbance in the community	• Reduces jail costs in current budget year • Linkage with treatment reduces future days spent in jail
Conditional Release. Release to pre-trial supervision with required treatment participation	People with psychiatric and substance use disorders and chronic health conditions charged with misdemeanors/low-level felonies	• Reduces jail costs in current budget year • Linkage with treatment reduces future days spent in jail
Screening/Brief Intervention.	All jail detainees	• Determines which detainees need which type of linkage services • Brief intervention alone reduces future substance use
Arrest and Pre-Trial Intervention for People Charged With Drug Offenses.	People charged with drug offenses who are eligible for various alternatives programs	• Reduces jail costs in current budget year • Linkage with programming reduces future days spent in jail
Reentry Services Linkage. Reentry linkage to behavioral health care services	All detainees with psychiatric and substance use disorders exiting jail	• Linkage with treatment reduces future arrests

Sources: *Steadman and Naples; Madras, Compton, Avula, et al.; Mancuse and Felver; Ehlers and Ziedenberg*[17]

Health care reform laws themselves, however, are not enough to fully realize cost savings and increase public safety. It is imperative that this Council and State and local leaders work toward implementation that will result in a landscape that fully realizes the potential of reforms. To that end, we offer the following recommendations:

First, we recommend that State and local criminal justice entities be included in the planning of health care reforms and Medicaid program expansion. This includes leaders from the State Department of Corrections, along with sheriffs and officials from county boards that fund local jails around the state. These leaders must be made aware of the opportunities and potential brought forth by health care reforms and the changing landscape. They will be knowledgeable and important partners in implementation.

Second, we recommend that Illinois draw on the latest science and research about what works in health care, behavioral health treatment, and management of justice-involved populations. Several federal agencies, including the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute of Corrections (NIC), have articulated evidence-based practices that should inform expansion of intervention programs for justice populations.

Third, we recommend that the Medicaid program partner with criminal justice leaders to expedite enrollment among justice-involved populations. There will be many thousands of newly eligible individuals in the criminal justice system, most of whom have little experience with health insurance. Many will also have substance use or mental health conditions (or both) that hinder their ability to remain engaged in complicated or lengthy enrollment processes. The justice system presents a window of opportunity to enroll large numbers of these newly eligible.

The Medicaid program may well want to consider presumptive eligibility for behavioral health treatment services among the justice-involved population maximize the impact. Presumptive eligibility will allow treatment to proceed immediately after a criminal justice referral, rather than waiting 30 days or more for eligibility evaluation. Simply, the faster we get a motivated offender into treatment, the more likely he or she is to engage in treatment and recovery.

Finally, we recommend that the State build on existing infrastructure to manage and coordinate care for chronic diseases and conditions among individuals passing through courts, jails, and prisons across Illinois. This type of infrastructure would facilitate provider network management and maintain relationships between the Medicaid program, justice system entities, health care and treatment providers. It would **ensure vital cost containment** and continuity of care for a population that greatly needs it.

Summary

Health care reform has the potential to catalyze large-scale, positive change in communities across the country. To improve recovery outcomes and recidivism reduction for jail populations, all stakeholders must work together to plan for ACA implementation. The reality of chronic health conditions must be acknowledged, and the standards of care for such conditions must be woven into the new systems. The goal of treatment intervention services should be durable recovery, using evidence-based practices and including the provision of longer-term care and management. With cost savings as a key driver for local communities, health care services should be protective of the public's safety and delivered in the most cost-effective, community-based treatment environment. They must be coordinated between county correctional systems and community service providers, and integrated with primary care. There are numerous proven models and lessons learned from many states; with expanded health care coverage under the ACA, these models can be adapted and brought to scale in communities and jurisdictions across the country.

States, counties, other jurisdictions and providers need to communicate and collaborate with one another to influence and plan for how the ACA will be implemented in their states. Those involved in the implementation of health care reform at state and local levels must work together to advocate and implement reforms that address the long-term health care needs of individuals with chronic health conditions. Success in implementing health care reform has the potential to result in reduced crime, recidivism and criminal justice expenditures as well as healthier and safer communities across the country.

Thank you again for the opportunity to speak here today. I am glad to answer any questions you may have.

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[1] Illinois Department of Corrections. (2010). Annual Report FY09. Springfield, IL: author.

[2] Illinois Criminal Justice Information Authority. (2008).Trends and Issues 2008: A Profile of Criminal and Juvenile Justice in Illinois (1995-2005). Springfield, IL: author.

[3] Binswanger IA, Krueger PM and Steiner JF. "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared With the General Population." *Journal of Epidemiological Community Health,* 63(11): 912¬–919, 2009.

[4] Brecht M, Anglin D and Lu T. *Estimating Drug Use Prevalence Among Arrestees Using ADAM Data: An Application of a Logistic Regression Synthetic Estimation Procedure.* Los Angeles: UCLA Integrated Substance Abuse Programs, 2003; Steadman HJ, Osher FC, Robbins PC, et al. "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services,* 60(6): 761–765, 2009; Center for Mental Health Services' GAINS Center. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails.* Delmar, NY: Center for Mental Health Services' GAINS Center, 2002 (revised 2004).

[5] Office of National Drug Control Policy. (2009). *ADAM II: 2008 Annual Report.* Washington: Office of National Drug Control Policy, Executive Office of the President.

[6] James, D. J. (2004). *Profile of Jail Inmates, 2002.* Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.

[7] Mumola, C. J. and Karberg, J. C. (2006). *Drug Use and Dependence, State and Federal Prisoners, 2004.* Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.

[8] National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide. Washington: National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, 2006.

[9] Dennis ML and Scott CK. "Intervening in the Recovery Process." (Presented at the NIDA Meeting on Treatment and Recovery Process, Bethesda, MD, January 15–16, 2004.)

[10] National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

[11] Wang EA, White MC, Jamison R, Goldenson J, Estes M and Tulsky JP. "Discharge Planning and Continuity of Health Care: Findings From the San Francisco County Jail." *American Journal of Public Health,* 98(12):2182-84, 2008.

[12] Assuming that the average length of stay is 14 days: 500 jail beds x 26 time periods/year = 13,000.

[13] Karberg, JC and James DJ. Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002. Washington: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2005;.13,000 x 66 percent = 8,580.

[14] Steadman et al; 13,000 x 14.5 percent = 1,885.

[15] Ten percent of the population needing intervention: (8,580 + 1,885) x 10 percent = 1,046 x 14 days x $75/day in jail = $1,098,300.

[16] Savings resulting from diversion of 5 percent of IDOC admissions = 5% x 36,837 annual admissions (FY09) x cost of 1 year of incarceration ($24,899 in FY09) = $45,860,223.15

[17] Table Sources:

Ehlers S and Ziedenberg J. *Proposition 36: Five Years Later.* Washington: Justice Policy Institute, 2006.

Madras BK, Compton WM, Avula D, et al. "Screening, Brief Interventions, Referral to Treatment (SBIRT) for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and 6 Months Later." *Drug and Alcohol Dependence,* 99(1-3): 280-295, 2009.

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Steadman H and Naples M. "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders." *Behavioral Sciences & the Law, 23*(2): 163–170, 2005.